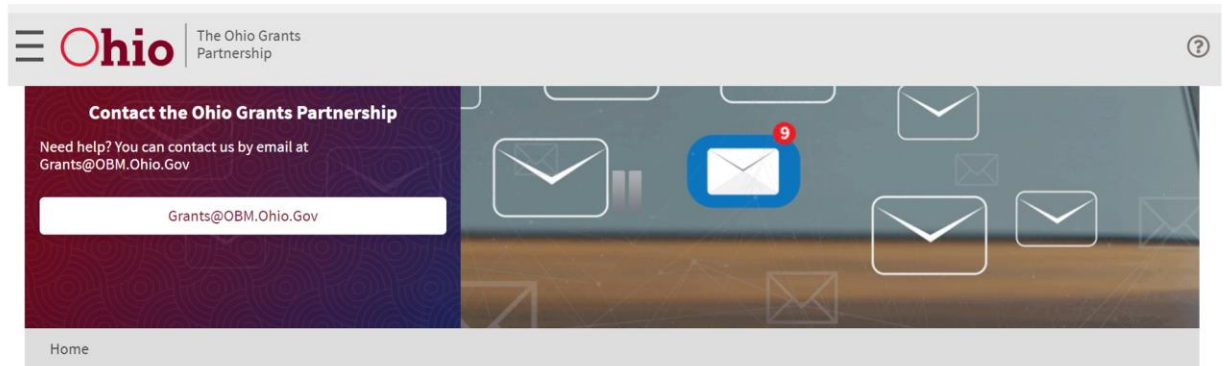


Opportunity #16922

INSTRUCTION FOR APPLYING FOR RELIEF FOR ASSISTED LIVING FACILITIES GRANT

- 1) Navigate your web browser to <https://grants.ohio.gov/fundingopportunities.aspx>



The Ohio Grants Partnership

- 2) This step is only required for providers who do not have an OAKS Supplier ID.

If you do not have a supplier ID, you should obtain one before you begin this application.

If you need a supplier ID, please find the job aide in the attachments called: "SSR Instructions," follow those instruction and come back to the grants portal after you have a supplier ID.

- 3) Proceed to application by clicking "Register for the funding opportunity".

Register for this Funding Opportunity

- 4) Please complete any fields with asterisks *. These are required to complete the application.

Select Your Organization Type

* v

- 5) Verify basic funding opportunity information at top of page.

Funding Opportunity	
Funding Opportunity ID 16922	Funding Opportunity Title Relief for Assisted Living Facilities
Primary Funding Organization N/A - State Agency Administered	Awarding Agency Department of Medicaid
Project Period Start Date	Project Period End Date
Application Due Date 05/06/2022	CFDA Number/Title

- 6) Enter MY ORGANIZATION INFORMATION:

*(*This information must correspond with your OAKS Supplier ID):*

- a) Select Your Organization Type
- b) *Address
- c) *City
- d) *Zip code
- e) *County
- f) Congressional District
- g) Please enter "0" for DUN

Select Your Organization Type

* v

Organization Name
Please fill out this field.

*

Address 1
Please fill out this field.

*

Address 2

City
Please fill out this field.

*

State

✓ v

Zip Code
Please fill out this field.

*

Zip+4

County

* v

Congressional District
Please select an item in the list.

* v

DUNS
Please fill out this field. If you do not have a DUNS number, please enter a zero. DUNS must be 9 digits.

*

7) Application Overview:

- a) Below is a basic description of this funding opportunity.

Project Description

In December of 2021, the Ohio General Assembly passed Amended Substitute House Bill 169 to provide additional relief to health care providers to support recovery from the COVID-19 pandemic. Included in the relief are funds intended to assist Residential Care Facilities with some of the added cost of the COVID-19 pandemic and to support the continued provision of Assisted Living services.

8) Payment Information:

- a) You may search your State of Ohio Supplier ID to associate with this grant application. (Please note that the address you provide for your organization above must match at least one address on file with your OAKS Supplier ID).

Payment Information

If you have a State of Ohio Supplier ID and have established banking with that Supplier ID, you can associate this application with your State of Ohio Supplier account to receive grant payments via electronic funds transfer. If you have a State of Ohio Supplier ID, please use the lookup tool to select your ID. If you submit a lookup and the results are excessive, add part of your address to the search criteria and try again. Applications without a Supplier ID or applications where the Supplier ID does not have banking associated in the State of Ohio system will be processed via check and mailed. If you wish to register as a supplier or update your banking information, you may do so at <https://supplier.ohio.gov>. Note that this process may take several days and will delay your ability to complete this application until the process is complete.

Lookup 🔍

9) Additional Questions:

- a. **Please enter your facility's 5-digit INVITATION NUMBER:**
- This unique five-digit Invitation ID can be found on the homepage of the ODA COVID-19 Care Center. The code begins with '55' (e.g., '55000').

Please enter your facility's 5-digit INVITATION NUMBER (e.g., 55000). Limit of 1500 Characters

Please fill out this field.

*

- b. **Please enter your 5-digit Residential Care Facility License Number:**
- This is the license number provided by the Ohio Department of Health, ending in 'R'.

(e.g., '1234R').

Please enter your Ohio Dept of Health license number (e.g., 1234R).
Please fill out this field. Limit of 1500 Characters

*

c. Please enter your 10-digit OAKS Supplier ID:

-You must first register as an OAKS supplier to complete this application.

PDF instructions are included on this application page under 'Attachments.'

Please enter your 10-digit OAKS Supplier ID.
Please fill out this field. Limit of 1500 Characters

*

d. Please enter your facility's name:

-Please enter your facility name as it appears on your ODH license.

Please enter your facility's name.
Please fill out this field. Limit of 1500 Characters

*

e. Please enter your facility's tax ID/EIN.

-Please enter your facility's 9-digit tax ID/EIN number.

(e.g., xx-xxxxxxx).

Please enter your facility's tax ID/EIN (e.g., 12-3456789).
Please fill out this field. Limit of 1500 Characters

*


10) Required Documents:

-No documents need to be submitted with this grant application.

Required Documents

The document(s) listed in the Opportunity Details must be required when you register. When applicable, instructions or templates will be provided in the Attachments section. Only PDF, Microsoft Word, PowerPoint or Excel formats will be accepted.

Upload File(s)

 Add Files

11) Compensated Officials:

-Please select the response that accurately reflects your facility's situation; most facilities will check 'NO'.

Compensated Officials

In your organization's preceding completed fiscal year, did your organization receive 80 percent or more of its annual gross revenues in Federal awards and \$25,000,000 or more in annual gross revenues from Federal awards?

☐ Yes ☐ No ☒

12) Agreement:

-Please enter the first name, last name, title, email address, and phone number of the "main executive" for the facility.

Agreement

Authorized Representative:

The Authorized Representative is the main executive within your organization who is authorizing acceptance of the funds on behalf of your organization. A different person must be listed as the Authorized Representative and Grant Contact.

First Name
Please fill out this field.

Last Name
Please fill out this field.

Title
Please fill out this field.

Email
Please fill out this field.

Phone
Please fill out this field.

13) Grant Contact:

- Please enter the first name, last name, title, email address, and phone number of the person responsible for completing this grant application and responding to questions. This should be a different person from the main executive.*
- If you name the same person for Executive and Contact, the structure of the portal still requires that you provide two different email addresses*

Grant Contact:

The Grant Contact is the main person who will be contacted for monitoring or other questions regarding the use of funds. The Grant Contact will also be responsible for reporting in the Ohio grants portal on behalf of the organization. A different person must be listed as the Authorized Representative and Grant Contact.

First Name Please fill out this field.	Last Name Please fill out this field.
<input type="text"/>	<input type="text"/>
Title Please fill out this field.	
<input type="text"/>	
Email Please fill out this field.	Phone Please fill out this field.
<input type="text"/>	<input type="text"/>

14) The “I Agree” box:

-The I AGREE box should be selected when you are ready to proceed with the final application.

As the duly authorized representative of the registered assisted living facility, I affirm that I have authority to apply for funding on behalf of the facility. By submitting this form, I certify that it is true, complete, and accurate to the best of my knowledge, information, and belief. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (Ohio Revised Code 2921.13).

By submitting this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

☐ I Agree *Please check this box if you want to proceed.*

15) The “Submitted By” box:

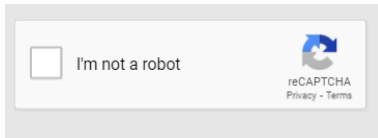
-A drop-down-option is provided to allow you to choose either the Executive or Contact who you named above.

Submitted By
Please select an item in the list.

*

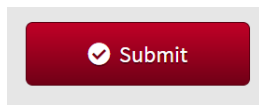
16) The “I’m not a robot” box:

-The “I’m not a robot” box must be checked for the final application.



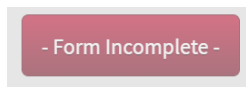
17) The “Submit button” box:

-The “Submit button” will finalize application. If you receive a Form Incomplete button, please review the application for any blank required fields. Once all required fields are complete, the “Submit Button” will appear.



18) The “form Incomplete Box” box:

If you do not have a Submit button, you should see a Form Incomplete button instead. Review your application. Any field that contains a red highlight is a required field that has not been completed. In addition, the "I agree" field must be checked on this page. You cannot submit until your application is complete and you agree to the terms.



19) **PLEASE NOTE:** This application must be completed in one sitting. You cannot save and return to finish the application at a different time.

20) If you have any further questions concerning this Grant or the application process, please contact: RCFRelief@medicaid.ohio.gov